CITY OF CANTON
PHYSICIAN'S STATEMENT FORM

Human Resources Facsimile: 330/489-3368

THIS FORM SHOULD BE SUBMITTED WHENEVER YOUR PHYSICIAN DETERMINES OR ADJUSTS YOUR ESTIMATED RETURN TO WORK DATE. (SEE SECTION "F")

TYPE OF LEAVE: _____
(SICK LEAVE, CONTINUED DISABILITY, INJURY LEAVE, LEAVE WITHOUT PAY)

EMPLOYEE NAME: _____ DEPARTMENT _____

PHYSICIAN'S NAME, ADDRESS & PHONE: _____

_____

_____

PHYSICIAN: Please provide the following information regarding the above-named employee:

(a) Date of Last Treatment: _____

(b) All Medical Conditions Being Treated: _____

_____

(c) Indicate all Medications and any side effects: _____

(d) Estimated Duration of Disability: _____

(e) Prognosis For Recovery: _____

(f) Estimated Return to Work Date: _____

(g) Further comments: _____

_____ _____
DATE SIGNATURE OF PHYSICIAN

RELEASE FOR SICK LEAVE, CONTINUED DISABILITY & LEAVES OF ABSENCE

I, the undersigned, grant permission to my treating physician to release the nature of my current injury or condition, to the City of Canton, and their authorized representatives.

I expressly waive all provisions of law which forbid any person or persons who may medically attend, treat, or examine me from disclosing such knowledge or information to the representative(s) of the City of Canton.

Employee's Signature _____

RELEASE FOR INJURY LEAVE ONLY

I, the undersigned, grant permission to my treating physician to release all medical, physical and psychological records, including doctor's notes of any kind, pertaining to my current injury or condition, to the City of Canton, and their authorized representatives.

I expressly waive all provisions of law which forbid any person or persons who may medically attend, treat, or examine me from disclosing such knowledge or information to the representative(s) of the City of Canton.

Employee's Signature _____